MEDICAL DAY TREATMENT
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A. TYPE OF HANDBOOK

Part H, Division III, Adult Medical (Mental Health) Day Treatment Services, is the service-specific portion of the Wisconsin Medical Assistance Provider Handbook. Part H, Division III, includes information for providers regarding provider eligibility criteria, recipient eligibility criteria, covered services, prior authorization procedures, and billing instructions. Use Part H, Division III in conjunction with Part A of the Wisconsin Medical Assistance Provider Handbook, which includes general policy guidelines, regulations, and billing information applicable to all types of Wisconsin Medical Assistance Program (WMAP) providers.

Providers who are also certified to provide other WMAP covered mental health or alcohol and other drug abuse (AODA) services should refer to the appropriate service specific handbooks for information on those services. Part H, Division I is for use by Non-51.42 Board-Owned-and-Operated Clinics providing mental health and AODA services. Part H, Division II is for use by 51.42 Board-Owned-and-Operated Clinics providing mental health and AODA services. Part H, Division IV is for AODA Day Treatment Providers. Part H, Division V is for Community Support Program (CSP) providers. Separate certification is required for each of these programs. The provider should contact EDS for certification materials.

B. PROVIDER INFORMATION

Provider Eligibility and Certification

In order to be certified as a WMAP Medical Day Treatment provider, all of the following requirements must be met:

- The provider is certified by the Division of Community Services (DCS) of the Department of Health and Social Services (DHSS) as meeting the day treatment requirements under HSS 61.75, Wis. Admin. Code. To obtain information on certification under HSS 61.75 providers must contact:

  Program Certification Unit
  Division of Community Services
  Post Office Box 7851
  Madison, WI 53707
  (608) 266-0120

- The day treatment program is planned for and directed by designated members of an interdisciplinary team that includes a social worker, a psychologist, an occupational therapist, a registered nurse or a physician, physician's assistant, or another appropriate health care professional.

- A registered nurse and a registered occupational therapist (OTR) are on duty to participate in program planning, program implementation, and daily program coordination.

- For purposes of daily program performance, coordination, guidance, and evaluation, each group is staffed by one qualified professional staff member such as an OTR, masters degree social worker, registered nurse, licensed psychologist or masters degree psychologist, or one certified occupational therapy assistant and one other paraprofessional staff person.

- A written patient evaluation involving an assessment of the patient's progress by each member of the multidisciplinary team is made at least every 60 days.

A provider meeting these eligibility requirements for medical day treatment who wishes to be certified as a WMAP medical day treatment provider must contact:

B. PROVIDER INFORMATION (continued)

EDS
Attn: Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

Providers are required to submit a copy of the approval letter from DCS to verify that they have been certified as a medical day treatment program under HSS 61.75, Wis. Admin. Code. Providers are encouraged to apply for certification materials through EDS prior to the time of their DCS certification site visit to ensure the earliest possible certification effective date.

Scope of Service
The policies in Part H, Division III govern services provided within the scope of the practice as defined in HSS 107.13 (4), Wis. Admin. Code. Covered services and related limitations are given in Section II of this handbook.

Reimbursement
Medical day treatment providers are reimbursed at the lesser of the provider's usual and customary charge or the maximum allowable fee established for that provider by the DHSS. The maximum allowable fee is a comprehensive hourly rate which is paid for any allowable day treatment services regardless of which staff person(s) provided the service or whether the service provided was a group or individual service. Providers who want the maximum allowable fee established for their program should contact:

Mental Health/AODA Policy Analyst
Bureau of Health Care Financing
Division of Health
Post Office Box 309
Madison, WI 53701

Provider Responsibilities
Specific responsibilities as a WMAP provider are stated in Section IV of Part A of the WMAP Provider Handbook. Reference Section IV of Part A for detailed information regarding:

- fair treatment of the recipient;
- maintenance of records;
- recipient requests for noncovered services;
- services rendered to a recipient during periods of retroactive eligibility;
- grounds for provider sanctions; and
- additional state and federal requirements.

C. RECIPIENT INFORMATION

Eligibility For Medical Assistance
Recipients eligible for Medical Assistance receive Medical Assistance identification cards. The identification cards include the recipient's name, date of birth, 10-digit Medical Assistance identification number, medical status code, and, when applicable, an indicator of private health insurance coverage, managed care program coverage, and Medicare coverage.

C. RECIPIENT INFORMATION (continued)

Recipients receive Medical Assistance identification cards on a monthly basis. All Medical Assistance identification cards are valid only through the end of the month for which they are issued. It is important that the provider or the designated agent check a recipient's Medical Assistance identification card prior to providing service to determine the recipient's eligibility and if there are any limitations to the recipient's coverage.

Section V of Part A of the WMAP Provider Handbook provides detailed information regarding eligibility for Medical Assistance, Medical Assistance identification cards, temporary cards, restricted cards, and eligibility verification. Review Section V of Part A carefully before rendering services. A sample Medical Assistance identification card is found in Appendix 7 of Part A of the WMAP Provider Handbook.

Medical Status

Medical Assistance recipients are classified into one of several eligibility categories. These categories allow for a differentiation of benefit coverage. Refer to Section V of Part A of the WMAP Provider Handbook for additional medical status information.

Copayment

Except as noted below, all recipients are responsible for paying part of the costs involved in obtaining medical day treatment services. The procedure codes and their applicable copayment amounts are in Appendix 4 of this handbook.

Providers are reminded of the following copayment exemptions:

- Emergency services.
- Services provided to nursing home residents.
- Services provided to recipients under 18 years of age.
- Services provided to a pregnant woman if the services are related to the pregnancy.
- Services covered by a WMAP-contracted managed care program to enrollees of the managed care program.
- Family planning services and related supplies.

Copayment is collected from the recipient by the provider of service. Applicable copayment amounts are automatically deducted by EDS from WMAP payments. Do not reduce the billed amount of the claim by the amount of recipient copayment.

Managed Care Program Coverage

WMAP recipients enrolled in WMAP-contracted managed care programs receive a yellow Medical Assistance identification card. This card has a six-character code in the "Other Coverage" column designating the recipient's managed care program. The codes are defined in Appendices 20, 21, and 22 of Part A of the WMAP Provider Handbook.

Providers must always check the recipient's current Medical Assistance identification card for managed care program coverage before providing services. Claims submitted to EDS for services covered by WMAP-contracted managed care programs are denied.

C. RECIPIENT INFORMATION (continued)

For recipients enrolled in a WMAP-contracted managed care program, all conditions of reimbursement and prior authorization for medical day treatment services are established by the contract between the managed care programs and certified providers.

Additional information regarding managed care program noncovered services, emergency services, and hospitalizations is included in Section IX of Part A of the WMAP Provider Handbook.

A. INTRODUCTION

Day treatment or day hospital means a nonresidential program in a medically supervised setting that provides case management, medical care, psychotherapy and other therapies, including recreational, physical, occupational and speech therapies, and follow-up services, to alleviate problems related to mental illness or emotional disturbances. Day treatment services are provided by an interdisciplinary team on a routine, continuous basis for a scheduled portion of a 24-hour day and may include structural rehabilitative activities including training in basic living skills, interpersonal skills and problem-solving skills (HSS 101.03 (37) Wis. Admin. Code).

Adult medical day treatment services are covered for recipients who are 18 years of age or older. Refer to Section II-D of this handbook for information about day treatment services for individuals under the age of 18.

B. COVERED SERVICES

Requirements for Medical Day Treatment Services

Pursuant to HSS 105.24 and HSS 107.13(4), Wis. Admin. Code, medical day treatment services are a covered benefit when the following conditions are met:

- a physician prescribes the services in writing;
- the provider is certified by the Wisconsin Medical Assistance Program (WMAP) as described in Section I of this handbook;
- before becoming involved in the day treatment program, the recipient is evaluated through the use of the functional assessment scale provided by the department to determine the medical necessity for day treatment and the person's ability to benefit from it (refer to Appendices 11 and 12 of this handbook for instructions on the completion of the functional assessment and a sample functional assessment form);
- a treatment plan is developed, based on the initial evaluation, and includes measurable, individual goals, the specific treatment modalities, including identification of the specific group or groups, to be used to achieve these goals, and the expected outcomes of treatment;
- each group is led by a qualified professional staff person (i.e. a registered occupational therapist [OTR], masters degree social worker, registered nurse [RN], licensed psychologist or masters degree psychologist) or one certified occupational therapy assistant and one other paraprofessional staff person. The qualified staff person(s) must be physically present throughout the group session and must perform or direct the service; and
- the supervising psychiatrist approves, signs, and dates the plan for that recipient, and reviews and signs the plan no less frequently than once every 60 days.

Covered Medical Day Treatment Services

To provide guidance to providers regarding HSS 107.13(4)(a), Wis. Admin. Code, the following are examples of services covered by the WMAP when they are specifically identified in the recipient's treatment plan as being necessary modalities toward the achievement of measurable goals and when all requirements for medical day treatment services (listed above) are met. The examples are:

- Psychiatric services including assessments, psychotherapy, and medication management. Medication management may be performed by an RN. Group services related to medication effects and side effects are also allowed services.

B. COVERED SERVICES (continued)

- Other individual or group counseling services, supportive psychotherapy, and symptom management. Groups designed to educate the recipient about mental illness or about topics (such as AIDS), with the intent of maximizing the recipient's functioning in the community, are allowed services.
- Specific skill development in communications or problem solving. Examples would include stress management and assertiveness training.
- Specific skill development related to activities of daily living designed to enable the recipient to function at a higher level and to function independently. Examples would include personal hygiene activities, cooking, budgeting, health, and nutrition.
- Pre-employment services, which are not job-specific, to assist the recipient in gaining and using skills necessary to undertake employment. These services would include activities to reduce anxiety or to manage symptoms on the job, and education about appropriate job-related behavior.
- Other occupational, physical, social, recreational, or speech therapies, recognized in the professional literature as acceptable and effective treatments, which enable adults with acute or chronic mental illness to function with greater independence.
- Face-to-face crisis intervention services may be provided when they are consistent with the recipient's overall treatment goals, even though they are not identified in the treatment plan.
- AODA treatment and educational services may be provided to medical day treatment recipients when the staff providing the services is knowledgeable about AODA issues and is knowledgeable about the special needs of individuals who have a co-existing mental illness. However, providers must still meet the staffing requirements identified in Section I of this handbook, e.g. at least one qualified staff person must lead the service and be present in the room and throughout the group. Therefore, an AODA service may be provided directly by a master's level psychologist who is knowledgeable about AODA issues or the services may be provided conjointly by a certified AODA counsellor and an RN (or some other qualified staff person).

Completion of the functional assessment form is also a covered service whether or not the recipient is eligible for medical day treatment based on the assessment. Refer to Appendix 4 of this handbook for the appropriate procedure codes to be used for billing both positive and negative functional assessments.

C. DOCUMENTATION

The recipient's medical record must contain copies of the functional assessment and treatment plans required under HSS 107.13(4)(a), Wis. Admin. Code, and the evaluations of progress required under HSS 105.24(1)(b)3, Wis. Admin. Code. The recipient's medical record must include signed and dated notes for all services billed to the WMAP. Providers are referred to HSS 106.02(9), Wis. Admin. Code, for requirements pertaining to documentation of services.

C. DOCUMENTATION (continued)

HSS 106.02(9)(a)1-8, Wis. Admin. Code, requires that providers document the following in the recipient's medical record:

- the full name of the recipient;
- the identity of the person who provided the service to the recipient;
- an accurate, complete, and legible description of each service provided;
- the purpose of and need for the services;
- the quantity, level, and supply of service provided;
- the date of service;
- the place where the service was provided; and
- the pertinent financial records.

Reviews of provider records have sometimes revealed that providers have not adequately documented the purpose of groups provided as a part of day treatment, the recipient's needs as they relate to the group and the specific goals the recipient is attempting to meet by taking part in the group, or the recipient's response to the group intervention. Providers who fail to provide this documentation will be out of compliance with HSS 106.02(9)(a), Wis. Admin. Code.

D. HEALTHCHECK "OTHER SERVICES"

Day treatment services as described in this handbook are limited to adults 18 years of age and older. The WMAP considers requests for medical day treatment services for individuals under 21 years of age when the following conditions are met:

- there is verification of a comprehensive HealthCheck screening prior to the request (visit verification cards which are given at the completion of a comprehensive screen are available free of charge from the State Division of Health Forms Center);
- the service is allowed under the Social Security Act (i.e., is a "medical" service);
- the service is "medically necessary" and "reasonable"; and
- a currently covered service is not appropriate to treat the identified condition.

The WMAP has developed unique policies and procedures for reimbursing mental health day treatment to children and adolescents who meet the requirements for HealthCheck Other Services. All such requests are subject to prior authorization.

Refer to Section IV of Part A of the WMAP Provider Handbook for additional information on HealthCheck "Other" Services.

E. NONCOVERED SERVICES OR RELATED LIMITATIONS

As specified in HSS 107.13(4)(d), Wis. Admin. Code, the following are not WMAP-covered medical day treatment services:

1. Day treatment services which are primarily recreation-oriented and which are provided in non-medically supervised settings such as 24-hour day camps, or other social service programs. These include sports activities, exercise groups, and activities such as craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours.
2. Day treatment services which are primarily social or educational in nature.
3. Consultation with other providers or service agency staff regarding the care or progress of a recipient.

E. NONCOVERED SERVICES OR RELATED LIMITATIONS (continued)

4. Prevention or education programs provided as an outreach service, case-finding, and reading groups.
5. Aftercare programs, provided independently or operated by or under contract to boards.
6. Medical day treatment for a recipient with a primary diagnosis of alcohol or other drug abuse or dependence.
7. Day treatment provided in a recipient's home or away from the site of the day treatment program.
8. Court appearances except when necessary to defend against commitment.

In addition, HSS 107.13(4)(a) through (c) does not allow day treatment reimbursement for the following services or circumstances:

1. Day treatment services in excess of five hours a day or 120 hours a month.
2. Day treatment services in excess of 90 hours in a calendar year which have not been prior authorized.
3. Day treatment services provided to recipients with inpatient status in a hospital in excess of 20 hours per inpatient admission or to hospital inpatients not scheduled for discharge.
4. Day treatment services provided to recipients with inpatient status in a nursing home which have not been prior authorized. No more than 40 hours of service in a calendar year may be authorized for nursing home recipients.
5. Day treatment services provided to individuals who were not shown as being able to benefit from day treatment by the functional assessment.
6. Psychotherapy services, occupational therapy services, or other services provided as component parts of a recipient's day treatment program when these services are separately billed.
7. Day treatment services provided to recipients who are concurrently receiving psychotherapy, occupational therapy, or AODA services without prior authorization for the day treatment services.
8. More than two series of day treatment in one calendar year related to separate episodes of acute mental illness.
9. Day treatment services provided to recipients who are receiving WMAP-reimbursed community support program services.

A. GENERAL REQUIREMENTS

Prior authorization safeguards against unnecessary utilization of care, promotes the most effective and appropriate use of available services, and assists in cost containment. Providers need prior authorization for certain specified services before delivery, unless the service is an emergency. Payment is not made for services provided either prior to the grant date or after the expiration date indicated on the approved prior authorization request form. If the provider renders a service which requires prior authorization without first obtaining authorization, the provider is responsible for the cost of the service.

B. SERVICES REQUIRING PRIOR AUTHORIZATION

As specified in HSS 107.13(4)(b), Wis. Admin. Code, prior authorization is required from EDS prior to the provision of services for:

- Day treatment services provided beyond 90 hours in a calendar year;
- All day treatment services provided to recipients with inpatient status in a nursing home;
- All day treatment services provided to recipients who are concurrently receiving psychotherapy, occupational therapy or AODA services.

Providers are advised that prior authorization does not guarantee payment. Provider eligibility, recipient eligibility, and medical status on the date of service, as well as all other Wisconsin Medical Assistance Program (WMAP) requirements, must be met prior to payment of the claim.

C. PRIOR AUTHORIZATION CRITERIA

The guidelines for prior authorization of medical day treatment services are in Appendix 10 of this handbook. The guidelines represent generally accepted parameters by which individual requests can be adjudicated. They are used along with the clinical judgement of the WMAP's mental health consultant to adjudicate prior authorization requests.

The guideline format divides the delivery of medical day treatment services into three categories:

- rehabilitation (for an initial, acute, mental health problem);
- maintenance (for a long-term, relatively stable, mental health problem); and
- stabilization (for decompensation or acute exacerbation of a long-term, mental health problem).

The guidelines are based on an analysis of actual statewide data for WMAP medical day treatment services.

Providers are reminded that WMAP consultants review and adjudicate prior authorization requests on a case-by-case basis. It is, therefore, essential that adequate explicit clinical information be provided on each prior authorization request. Prior authorization requests may be returned to providers for additional information when the initial request does not contain adequate information to adjudicate the request. Returned requests are not denials. Providers are responsible for providing adequate, updated, information to allow the mental health consultant to determine the appropriateness of the services being requested. The additional information must be added to the returned request, and resubmitted to EDS. Do not complete a new PA/RF.

D. PROCEDURES FOR OBTAINING PRIOR AUTHORIZATION

Section VIII of Part A of the WMAP Provider Handbook identifies procedures for obtaining prior authorization including emergency situations, appeal procedures, supporting materials, retroactive authorization, recipient loss of eligibility midway in treatment, and prior authorization for out-of-state providers.

Providers requesting prior authorization for medical day treatment must complete the PA/RF and the prior authorization day treatment attachment (PA/DTA). Samples of the PA/RF and PA/DTA along with completion and submittal instructions are in Appendices 6, 7, 8, and 9 of this handbook.

Send completed prior authorization request forms to:

EDS
Attn: Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Prior authorization request forms can be obtained by writing to:

EDS
Attn: Form Reorder
6406 Bridge Road
Madison, WI 53784-0003

Please specify the form requested and the number of forms desired. Reorder forms are included in the mailing of each request for forms. Do not request forms by telephone.

E. SPECIAL CIRCUMSTANCES AFFECTING PRIOR AUTHORIZATION

When to Request Prior Authorization

Because a provider may have no way of knowing whether or not a recipient has received services from another provider and has, therefore, reached the prior authorization threshold, providers are encouraged to request prior authorization as soon as possible when providing medical day treatment services. Because the WMAP ordinarily grants prior authorization to only one psychotherapy/AODA provider at a time, requesting prior authorization helps protect the provider against potential denial of services.

Any part of the 90 hours of service which may be reimbursed without prior authorization that is not used, is available for the recipient's use for the remainder of the calendar year.

Determination of Grant Dates

The prior authorization grant date (i.e., the first date of service which may be reimbursed under the authorization) is the date the prior authorization request is received at EDS unless the provider specifically requests otherwise. When a request is returned to the provider for additional information, the grant date does not change if returned in a timely manner.

E. SPECIAL CIRCUMSTANCES AFFECTING PRIOR AUTHORIZATION (continued)

Procedures for Backdating Prior Authorization Requests

Backdating of prior authorization requests up to two weeks prior to the date the prior authorization is received at EDS may be allowed at the discretion of the WMAP mental health consultant. The provider must request the backdating and must indicate the clinical rationale for the backdating on the prior authorization attachment or in a narrative submitted with the prior authorization request. The WMAP does not backdate requests for continuing authorization by the same provider.

Backdating for Services by Multiple Providers Exceeding the Prior Authorization Threshold

Providers may request backdating of prior authorizations to cover services which were denied because they exceeded the prior authorization threshold. In these cases, authorization may be granted for services provided more than two weeks prior to the receipt of the prior authorization request at EDS. Requests for backdating prior authorizations are considered if:

- More than one medical day treatment provider provided service during the period for which the backdating is requested; and

- The provider must document an inability to obtain information from the recipient or other provider which would have allowed the provider to determine that prior authorization would have been required.

Service Interruptions

If a provider is unable to use all prior authorized services during the prior authorization grant period due to unforeseeable interruptions in service (e.g., recipient illness or vacation), the provider may request an extension of the grant period. The provider should write a letter indicating the change requested and the reason and attach it to a copy of the approved PA/RF and send these to the EDS Prior Authorization Unit. Gaps in service exceeding one month require special justification.

If a recipient transfers to another day treatment provider before the expiration of a prior authorization period, the provider should notify the EDS Prior Authorization Unit of the exact date care is terminated so that a new prior authorization may be granted. If a provider is requesting prior authorization for a recipient who has an approved prior authorization from another provider and the other provider will not cooperate with terminating their authorization, the requesting provider should include a signed letter from the recipient indicating that he or she is no longer receiving services from the other provider. Indicate specific beginning and end dates.

E. SPECIAL CIRCUMSTANCES AFFECTING PRIOR AUTHORIZATION (continued)

Concurrent Mental Health/AODA Prior Authorizations

Prior authorization is required for all medical day treatment services for individuals receiving concurrent mental health or AODA services under HSS 107.13(4)(b)1c. Wis. Admin. Code. Individuals involved in primary AODA treatment (intensive or day treatment) will generally not be eligible for concurrent medical day treatment. Medical day treatment may be granted concurrently with outpatient psychotherapy or AODA treatment when the provider demonstrates that all three of the following conditions are met.

1. The recipient is diagnostically appropriate for both services.

2. The providers are communicating with each other about the recipient's needs, the treatment is coordinated, and the day treatment services augment the other outpatient services.

3. One of the following statements is true:

   - There is a pre-existing relationship between the recipient and the outpatient provider.

   - The recipient has appropriate day treatment needs, but the recipient also has a need for specialized intervention which the day treatment staff is not trained to provide.

   - The recipient is transitioning from day treatment to outpatient services.

In general, a recipient who is able to benefit from outpatient services will not require as high a level of day treatment services and the consultant may modify the hours requested based on his or her clinical judgement. Refer to the consultant guidelines in Appendix 10 of this handbook for additional information.

A. COORDINATION OF BENEFITS

The Wisconsin Medical Assistance Program (WMAP) is the payer of last resort for any WMAP covered service. If the recipient is covered under health insurance, the WMAP reimburses that portion of the allowable cost remaining after all health insurance sources have been exhausted. Refer to Section IX of Part A of the WMAP Provider Handbook for more detailed information on services requiring health insurance billing, exceptions, and the "Other Coverage Discrepancy Report."

B. MEDICARE/ MEDICAL ASSISTANCE DUAL ENTITLEMENT

Recipients covered under both Medicare and Medical Assistance are called dual-entitlees. Claims for Medicare covered services provided to dual-entitlees must be billed to Medicare prior to billing Medical Assistance.

If the recipient is covered by Medicare, but Medicare denied the claim, a Medicare disclaimer code must be indicated on the claim, as indicated in the claim form instructions in Appendix 2 of this handbook.

C. QMB-ONLY RECIPIENTS

Qualified Medicare Beneficiary Only (QMB-only) recipients are only eligible for WMAP payment of the coinsurance and the deductibles for Medicare-covered services. Since Medicare does cover some medical day treatment services, claims submitted for QMB-only recipients for Medicare allowed services may be reimbursed.

D. BILLED AMOUNTS

Providers must bill the WMAP their usual and customary charge for services provided. The usual and customary charge is the amount charged by the provider for the same service when provided to private-pay patients. For providers using a sliding fee scale for specific services, usual and customary means the median of the individual provider's charge for the service when provided to non-Medical Assistance patients. Providers may not discriminate against Medical Assistance recipients by charging a higher fee for the service than is charged to a private-pay patient.

Medical day treatment services are subject to recipient copayment as noted in Appendix 4 of this handbook. The billed amount should not be reduced by the amount of recipient copayment. The applicable copayment amount is automatically deducted from the WMAP-allowed payment.

E. CLAIM SUBMISSION

Paperless Claim Submission

As an alternative to submission of paper claims, EDS is able to process claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem. Claims submitted electronically have the same legal requirements as claims submitted on paper and are subjected to the same processing requirements as paper claims. Providers submitting electronically can usually reduce their claim submission errors. Additional information on paperless claim submission is available by contacting the Electronic Media Claims (EMC) Department at:

EDS
Attn: EMC Department
6406 Bridge Road
Madison, WI 53784-0009
(608) 221-4746

A Paperless Claims request form can be found in Appendix 3 of this handbook.

E. CLAIM SUBMISSION (continued)

Paper Claim Submission

Medical day treatment services must be submitted using the National HCFA 1500 claim form. A sample claim form and completion instructions are in Appendices 1 and 2 of this handbook.

Medical day treatment services submitted on any other paper form than the National HCFA 1500 claim form are denied.

The National HCFA 1500 claim form is not provided by the WMAP or EDS. It may be obtained from a number of forms suppliers. One such source is:

State Medical Society Services
Post Office Box 1109
Madison, WI 53701
(608) 257-6781 (Madison area)
1-800-362-9080 (toll-free)

Completed claims submitted for payment must be mailed to:

EDS
6406 Bridge Road
Madison, WI 53784-0002

Submission of Claims

All claims for services rendered to eligible WMAP recipients must be received by EDS within 365 days from the date such service was rendered. This policy pertains to all initial claim submissions, resubmissions, and adjustment requests.

Exceptions to the claim submission deadline and requirements for submission to Late Billing Appeals are in Section IX of Part A of the WMAP Provider Handbook.

F. DIAGNOSIS CODES

All diagnoses must be from the International Classification of Diseases, 9th Edition, Clinical Modifications (ICD-9-CM) coding structure.

Claims received without the appropriate ICD-9-CM code are denied.

The complete ICD-9-CM code book can be ordered by writing to the address listed in Appendix 3 of Part A of the WMAP Provider Handbook.

Providers should note the following diagnosis code restrictions:

- Codes with an "E" prefix must not be used as the primary or sole diagnosis on a claim submitted to the WMAP.
- Codes with an "M" prefix are not acceptable on a claim submitted to the WMAP.

G. PROCEDURE CODES

HCFA Common Procedure Coding System (HCPCS) codes are required on all medical day treatment claims. Claims or adjustments received without HCPCS codes are denied. Allowable HCPCS codes and their descriptions for medical day treatment are listed in Appendix 4 of this handbook.

The functional assessment procedure codes are subject to the six hour per two year limit on mental health evaluations. Functional assessments which cause this limit to be exceeded should be billed using the limitation-exceeded functional assessment codes.

H. PLACE OF SERVICE AND TYPE OF SERVICE CODES

Allowable place of service and type of service codes for medical day treatment services are included in Appendix 5 of this handbook.

I. FOLLOW-UP TO CLAIM SUBMISSION

It is the provider's responsibility to initiate follow-up procedures on claims submitted to EDS. Processed claims appear on the Remittance and Status Report either as paid, pending, or denied. Providers are advised that EDS will take no further action on a denied claim until the information is corrected and the claim is resubmitted for processing. If a claim was paid incorrectly, the provider is responsible for submitting an adjustment request form to EDS. Section X of Part A of the WMAP Provider Handbook includes detailed information regarding:

- the Remittance and Status Report;
- adjustments to paid claims;
- return of overpayments;
- duplicate payments;
- denied claims; and
- Good Faith claims filing procedures.